DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 1 0

2. STATE: South Dakota

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42CFR 430.10
447.250-447.252 and 447.256-447.272

7. FEDERAL BUDGET IMPACT:
a. FFY 01 $ 361,058
b. FFY 02 $ 348,478

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, pages 1-3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Inpatient hospital payment methodology

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
James W. Ellenbecker

13. TYPED NAME:
James W. Ellenbecker

14. TITLE:
Secretary

15. DATE SUBMITTED:
11/1/2000

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
November 6, 2000

18. DATE APPROVED:
1/26/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
10/1/00

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
David R. Selleck

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: November 3, 2000

FORM HCFA-179 (07-92)

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INPATIENT HOSPITAL PAYMENT METHODOLOGY

INTRODUCTION

The South Dakota Medicaid Program has been reimbursing hospitals for inpatient services, with a few exceptions, under a prospective Diagnosis Related Group (DRG) methodology since January 1, 1985.

GENERAL

South Dakota has adopted the federal definitions of Diagnostic Related Groups, the DRG classifications, weights, geometric mean length of stay, and outlier cutoffs as used for the Medicare prospective payment system. The grouper program is updated annually as of October 1 of each year. Beginning with the Medicare grouper version 15 (effective October 1, 1997), South Dakota Medicaid Program specific weight and geometric mean length of stay factors will be established using the latest three years of non-outlier claim data. This three year claim database will be updated annually in order to establish new weight and geometric length of stay factors with each new grouper.

Hospital specific cost per Medicaid discharge amounts were developed for all instate hospitals using Medicare cost reports and non-outlier claim data for these hospital's fiscal year ending after June 30, 1996 and before July 1, 1997. An inflation factor, specific to the hospital's fiscal year end, was applied to the cost per discharge amounts of all hospitals with more than thirty (30) Medicaid discharges during the base year to establish target amounts for the period of October 1, **2000** through September 30, **2001**.

A cap on the target amounts has been established. Under this cap no hospital will be allowed a target amount that exceeds 110% of the statewide weighted average of all target amounts.

Out of state hospitals will be reimbursed on the same basis as the hospital is paid by the Medicaid Agency in the state in which the hospital is located. If the hospital's home state refuses to provide the amount they would pay for a given claim, payment will be at 70% of billed charges. Payment will be for individual discharge or transfer claims only, there will be no annual cost settlement with out of state hospitals.

SPECIFIC DESCRIPTION

Target amounts for non-outlier claims were established by dividing the hospital's average cost per discharge for non-outlier claims by the hospital's case mix index. To ensure budget neutrality, a hospital's target amount will be adjusted annual for any change in that hospital's case mix index resulting from the establishment of new program specific weight factors.

The case mix index for a hospital was calculated by accumulating the weight factors for all claims submitted during the base period and dividing by the number of claims.

The average cost per discharge for non-outlier claims was calculated by subtracting the charges for ancillary services on outlier claims, multiplied by the average ancillary cost to charge ratio, from the total allowable ancillary charges for the hospital. Total Medicaid days and discharges were reduced by the number of days and discharges from outlier claims to calculate the routine costs for non-outlier claims. Routine costs and ancillary costs related to non-outlier claims were added and then the total allowable costs were divided by the number of non-outlier discharges during the base period.

CAPITAL COSTS

Capital and education costs will be paid following the Medicare retrospective reasonable and allowable cost reimbursement methodology. The Medicare reduction of allowable cost for capital and education costs will not be used, rather 100% of allowable cost will be paid. Interim payments for capital and education costs will be made to instate hospitals that had more than thirty (30) Medicaid discharges during the hospital's fiscal year ending after June 30, 1996 and before July 1, 1997 on a perdiem basis. The interim rate is hospital specific and is calculated using the most recently reviewed Medicare cost report.

UPDATING OF TARGET AMOUNTS

Target amounts will be updated annually using the latest Consumer Price Index factor available at the time the new Medicare grouper is implemented each year (October 1). An adjustment will be made each year to correct any inaccuracy in the prior year's inflation factor.

TRANSFER PATIENTS

Payment will be allowed to the transferring hospital whenever a patient is transferred to another hospital regardless of whether the receiving hospital is paid under the DRG system or is an exempt hospital or unit.

The amount of payment made to the transferring hospital will be on a per diem basis. The per diem rate will be calculated by dividing the standard DRG payment for the particular stay by the geometric mean length of stay for the DRG. The per diem rate will then be multiplied by the number of days stay prior to the transfer. In no instance will the payment to the transferring hospital be any higher than the full DRG payment amount if the patient had been discharged home. The daily capital/education passthrough will be added to the DRG payment.

The receiving hospital will be paid a normal DRG payment unless the patient is again transferred to another hospital.

COVERED DIAGNOSTIC RELATED GROUPS

South Dakota will adopt all DRGs, except DRG 436 and 437, established in the version of the grouper program being used by the Department as of the admission date on the claim.

SERVICES COVERED BY DIAGNOSTIC RELATED GROUP PAYMENTS

The Department will adopt Medicare's definition of inpatient hospital services covered by DRG payment. As a result, billing for physician services must be made on a separate HCFA 1500 form.

OUTLIER PAYMENTS

Additional payments will be made to hospitals for discharges which meet the criteria of an "outlier". An outlier is a case that has extremely high charges which exceed cost outlier thresholds.

A claim will qualify for a cost outlier payment when 70% of billed charges exceed the larger of **$22,772** or 1.5 times the DRG payment for the claim. The additional payment allowed for a cost outlier will be 90% of the difference between 70% of billed charges and the larger of **$22,772** or 1.5 times the DRG payment. Effective October 1, 1991, and annually thereafter, the cost outlier threshold will be inflated annually using the same inflation factor used in updating the target amounts.

The total payment allowed for an outlier claim will be the DRG payment plus the outlier payment plus the daily capital/education amount for each day of the hospital stay.